U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED THIRTEENTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

September 26, 2013

The Honorable Eric Shinseki
Secretary
U. S. Department of Veterans Affairs
810 Vermont Ave. NW
Washington, DC 20420

Dear Secretary Shinseki,

As you know, the Department of Veterans Affairs confirmed September 20, 2013, that six veteran deaths have been linked to delayed colorectal cancer screenings at the Columbia, S.C., VA Medical Center. Through its investigative efforts, the House Committee on Veterans' Affairs has also learned of delays in care at the Augusta, Ga., VAMC and within the VA North Texas Health Care System. An October 2012 internal VA memo referenced 4,503 unresolved consults for GI endoscopy at the Augusta, Ga. VAMC, resulting in five institutional disclosures.[1] Additionally, a September 2012 internal VA memo referenced more than 36,000 unresolved consults within the VA North Texas Health Care System dating back nearly a decade.

Pursuant to the congressional oversight authority of the House Committee on Veterans' Affairs, please provide the following information regarding the aforementioned facilities:

- All performance reviews of all Augusta, Ga., VAMC directors, regional directors, chiefs of staff as well as anyone responsible for overseeing patient safety from 2002 to present.

- All performance reviews of all hospital directors, regional directors, chiefs of staff as well as anyone responsible for overseeing patient safety within the VA North Texas Health Care System from 2002 to present.

- A list of all performance bonuses, awards and special pay for all Augusta, Ga., VAMC directors, regional directors, chiefs of staff as well as anyone responsible for overseeing patient safety from 2002 to present, as well as the justification for said disbursements.

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[1] According to VHA HANDBOOK 1004.08 dated October 2, 2012, "Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders, together with clinicians and other appropriate individuals, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in or is reasonably expected to result in death or serious injury."

- A list of all performance bonuses, awards and special pay for all hospital directors, regional directors, chiefs of staff as well as anyone responsible for overseeing patient safety within the VA North Texas Health Care System from 2002 to present, as well as the justification for said disbursements.

- A list of all disciplinary actions against all Augusta, Ga., VAMC directors, regional directors, chiefs of staff as well as anyone responsible for overseeing patient safety from 2002 to present, as well as documentation for said actions.

- A list of all disciplinary actions against all hospital directors, regional directors, chiefs of staff as well as anyone responsible for overseeing patient safety within the VA North Texas Health Care System from 2002 to present, as well as documentation for said actions.

- A list of all personnel held accountable in any way for any institutional disclosures related to the aforementioned unresolved consults, as well as documentation for said actions.

- A current account of any appointment backlogs, delays in care and/or unresolved consults that persist at the aforementioned facilities/systems.

- A current list of all institutional disclosures related to the aforementioned unresolved consults, broken down by facility and incident nature (i.e., death, injury type, etc.).

In addition, please advise what VA's methodology is to comprehensively cross-check for clinical indicators of harm as opposed to declaring any consult backlog as a "clerical" problem.

Finally, please provide a list of any other VA medical facilities where appointment backlogs, delays in care and/or unresolved consults persist, including the facilities identified in the September 13, 2013, deliverable and any facilities not previously identified by the Committee.

Thank you again for your dedication to our nation's veterans. If you have any questions, please contact Eric Hannel, Staff Director of the House Committee on Veterans' Affairs Subcommittee on Oversight & Investigations, or Mr. Harold Rees, Investigative Counsel, at (202) 225-3569.

Sincerely,

Mike Coffman

Mike Coffman
Chairman
Subcommittee on Oversight & Investigations

MC/eh